

# Hidden Valley Dentistry

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## **Bone Graft Informed Consent**

I \_\_\_\_\_, understand that when a tooth is extracted, the underlying bone tends to atrophy (shrink). Bone grafting is a method to reduce or offset this bone atrophy after a dental extraction, or to supplement bone around an implant, a large sinus cavity, or to treat pocketing around a tooth. Listed below are several types of bone grafting materials/techniques for you to select from:

Please indicate your selection by initialing beside your selection

\_\_\_\_\_ **Self** (Autogenous) graft: Transplants or grafts your own harvested bone, either small particles or in block form, for jaw rebuilding- very effective, but harvesting your bone is more painful and costly. ***This selection requires the procedure to be done by a specialist and is not an option here in our office.***

\_\_\_\_\_ **Donor Human** (Allograft) graft: Pre-packaged cadaver bone particles- very effective and at a reasonable cost, but there is a rare risk of disease (estimated at less than 1 occurrence out of every two million uses; > 1:2,000,000), and will preclude blood/tissue donations for 1 year or more at most blood banks. ***All Allografts are registered with the manufacturer, with your unique identifier and the exact identification number of the graft material, to maintain proper records.***

\_\_\_\_\_ **Synthetic** (Alloplast) graft: places synthetic/chemically derived bone substitutes- less effective, but at no risk for disease transmission.

Please read carefully and ask your surgeon if you have any questions regarding the following:

- I have been informed, and I understand the purpose, of the bone graft procedure.
- I understand that there may be risks and complications of any procedure including swelling, bruising, pain, bleeding, infection, altered sensation (usually numbness at the donor site), allergic reaction or other adverse reactions to medication or materials used during or after the procedure.
- I understand that there is no method to predict accurately the gum and bone healing capabilities in each patient following the placement of a bone graft; and that bone in it's healing process remodels and there is no method to predict the final volume of bone, thus additional grafting may be necessary.

- It has been explained to me that, in rare instances, bone grafts fail and must be removed. Lack of adequate bone growth into the bone graft replacement material could result in failure. No assurances or guarantees as to the outcome of the results of treatment or surgery can be made. I am aware that should the bone graft surgery fail, it may require further corrective surgery or the removal of the bone graft with possible corrective surgery associated with the removal. Should the bone graft surgery fail, I understand that alternative non-surgical prosthetic measures may have to be considered.
- I understand that **smoking and high blood sugar** (diabetes) may affect gum healing and may limit the success of the bone graft. I agree to follow my doctor's home care instructions. I agree to report to my doctor for regular examinations as instructed.
- **To my knowledge, I have given an accurate report of my health history.** I have also reported any unusual reactions to drugs, anesthetics, food, insect bites, pollen or dust, any blood or body diseases, gum or skin reactions, abnormal bleeding, or any other conditions related to my health. **Please Initial:** \_\_\_\_\_
- I understand and authorize medical/dental services for myself, including bone grafts and other associated surgery. I fully understand that during and following the contemplated procedure, surgery, or treatment, conditions may become apparent which warrant judgment of the doctor, additional or alternative treatment pertinent to the success of the comprehensive treatment. I also approve modifications in design, materials, or care, if it is felt this is for my best interest, including the decision not to proceed with a bone graft. ***You will be informed of any changes in the proposed treatment as they present.***

**I have reviewed the above information, and have had the opportunity to have any questions/concerns addressed. Based on the information presented by my doctor(s) regarding my diagnosis, the proposed treatment, the treatment alternatives, and the associated risks and complications of such treatment, I request that you perform the planned treatment.**

**Patient/Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness' Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Doctor's Signature** \_\_\_\_\_ **Site:** \_\_\_\_\_

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